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ABSTRACT

The depressed person is often trapped in a vicious cycle of dysfunctional thoughts and feelings of powerlessness. Young adults are prone to depression because of the intimacy versus isolation conflict. Young adulthood (ages 18-35) focuses on the search for intimacy, establishment of a career, and formation of a lifestyle. The failure to succeed in these areas can lead to feelings of despair, inadequacy and eventually depression. Middle-aged adults (ages 35-60) are at a crossroads. Someone in this stage of life may become depressed as a result of unfulfilled dreams . The counselor seeks to help depressed adults to regain control over dysfunctional thinking, find hope, and learn to live life with a positive attitude. Depression is characterized by inactivity, dullness and feelings of helplessness and loss of control, hopelessness, persistent empty mood, worthlessness, insomnia, fatigue, weight gain, suicidal thoughts, lack of concentration and excessive crying. One out of every four Americans suffers from depression at any given time. Environmental stressors, personal characteristics, and coping behaviors of the individual are major components. Guilt, shame, agony and self-blame are emotions experienced by the depressed person in a society that insists that "feeling good" is the only way to be. Depression can be classified as either reactive (stemming from an external event) or endogenous (responding to an internal, often unknown, process). Treatment, like depression itself, is multifaceted and should include a variety of cognitive, affective, behavioral and interpersonal learning components. Individual counseling, drug therapy, and exercise are all integral parts of the depression management program. The counselor's role is to teach the client to effectively manage his depression on a daily basis. (BHK)

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Depression in Young and Middle Adulthood:

A Summary of the Problem and Treatments

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Depression is misunderstood by those who have never experienced it; it is a dark world of despair with no light in sight, and the depressed person is trapped in a vicious cycle of dysfunctional thoughts and feelings of powerlessness. However, there is a way out for the client who is motivated to change and will go to any length to reach a positive existence. Young adults (ages 18 to 35) are prone to depression because of the intimacy versus isolation conflict. "One characteristic of the psychologically mature person is the ability to form intimate relationships. Before we can form such relationships, we must be sure of our own identities. Failure to achieve intimacy can result in isolation from others and a sense of alienation," Corey (1983, pp. 93-94). Young adulthood focuses on the search for intimacy, establishment of a career, and formation of a lifestyle. These choices are complex, at times overwhelming, and may involve many "shoulds." The failure to live up to those "shoulds" leads to feelings of despair, inadequacy, and eventually depression.

Middle aged adults (ages 35 to 60) are at a crossroads. "For most of us, it is a period when we reach the top of the mountain yet at the same time become aware that we must begin the downhill journey," Corey (1983, pp. 99). A person in this life stage may become depressed because his dreams of yesteryear do not match with his reality of today; this may result in a sense of meaninglessness about life, reexamination of commitments, or a midlife crisis. The person still has choices, but in the maze of dysfunctional thinking he cannot see those choices and loses his sense of hope. The counselor seeks to help depressed adults to regain control over dysfunctional thinking, find hope, and learn to live life with a positive attitude.

Summary of Problem

Monahan (1986, pp. 192) defines depression as, "A sadness greater and more prolonged than that warranted by any objective reason." It is characterized by withdrawal,

inactivity, dullness, and feelings of helplessness and loss of control. One of every four Americans suffers from depression at any given time. According to Ubell (1988), depression is neither an act nor a failure of willpower. He writes that it is a real disease which produces physical, emotional, and thinking symptoms. Many depressed persons recover with treatment; without treatment it can go on for years, perhaps ending in suicide. Because of increased awareness and diagnostic methods, physicians can more accurately identify and treat depression today. It seems that more people are depressed, possibly because we are more alert to the disease or because of the type of culture in which we live.

The symptoms of depression are many, including persistent empty mood, hopelessness, worthlessness, insomnia, weight gain, physical pains, excessive crying, restlessness, fatigue, lack of concentration, and suicidal thoughts (Ubell, 1988). According to Lerman and Baron (1981), surveys have shown that depression is the most frequently occurring mental disorder and the leading cause of psychiatric hospitalization in the United States. It is a multifaceted disease in that three major components are involved: environmental stressors, coping behaviors of the individual, and personal characteristics of the individual. Lerman and Baron (1981) go on to state that depression is idiosyncratic with regard to individual sources of and responses to potentially depressing experiences. This means that it is a personal disease; how a person responds to a particular situation depends on his view of that situation. What is depressing for one person may not be depressing to another. Because of this, Lerman and Baron (1981, pp. 86) state, "The potential for depression exists in all aspects of living." McBrien (1981, pp. 429) summarizes the problem as follows, "The depressed client is involved with much more than the mood we call depression. Along with feelings of sadness and the blues, depression includes low activity, self-criticism, pessimism, indecisiveness, and a negative view of self, of the world,

and of the future." According to Ubell (1988), depression afflicts more people under age 45 and fewer over age 65. It can emerge in adolescence but usually first appears in patients in their early 20's. Depression does run in families and may be caused partly by a chemical imbalance in the brain.

Between five and fifteen percent of the population suffer from severe depression (Hazleton, 1984). The vast majority of persons suffer from moderate depression but not to the extent that hospitalization is required. This moderate depression, however, carries with it a social stigma which says that all depression is either sick or wrong. Hazleton (1984, pp. 2-3) asks these questions, "How are we to see our depression, and how are we to deal with feeling bad when the world around us seems to insist on only feeling good?" Because of this stigma, the depressed person attempts to put on a front in order to hide his fear and shame. As Hazleton (1984, pp. 3) goes on to state, "We do not realize that everyone has experienced the same thing."

Depression also carries with it an overlay of emotions such as guilt, shame, agony, and self-blame. Hazleton (1984, pp. 31) states, "We become depressed about being depressed. The agony of depression often stems more from this overlay than from the original depression itself. The sense of "should-ness" is betrayed, for depression is never entirely personal; society is always watching. Yet by denying depression, we deny ourselves. We assume that since we are depressed, we are invalid. And this assumption merely feeds into the depression itself, creating a further overlay of agony and self-blame."

Sometimes a person grows impatient with his depression. He wants out of it because he is tired and wants never to feel depressed again. Hazleton (1984, pp. 53) states, "He wants out of experience. And he could achieve that certainly, but at a price. That price is repression. Fear of depression and self-hate for being depressed drives much

normal emotion underground. Rather than feel it, we'll repress it. And in this we are encouraged by the society we live in." The depressed person feels trapped and is telling himself he "should" be able to help himself. He is also caught up in creating a facade that tells the world he is just fine. He thinks that letting others see his depression will only make it worse. Hazleton, (1984, pp. 63) goes on to state, "The result is frightening. Repression can kill, both slowly and suddenly. We wrong ourselves by denying and repressing depression. Burdened by stereotypes and impossible ideals, we deny the validity of our own feelings; in fact, we deny what we feel."

Depression can be classified either as reactive or endogenous (Seligman, 1975). Reactive depression is the most common and stems from an external event, such as a death. Endogenous depression is a response to an internal process often unknown. "Depression is the common cold of psychopathology and has touched the lives of us all, yet it is probably the most dimly understood and most inadequately investigated of all the major forms of psychopathology," Seligman (1975, pp. 76). The universal hallmark of depression is a negative cognitive set. "Depressed people believe themselves to be even more ineffective than they actually are: small obstacles to success are seen as impassible barriers, difficulty in dealing with a problem is seen as complete failure, and even outright success is often misconstrued as failure," Seligman (1975, pp. 85). Even a small task may be seen as monumental to a depressed person. Whereas a nondepressed person feels that what he does matters, a depressed person often feels that what he does makes no difference. He believes that his response will not work. Seligman (1975, pp. 93) states, "When a person is depressed, his view of the future is bleak; he sees himself as helpless and hopeless. The depressed person believes or has learned that he cannot control those elements of his life that relieve suffering, bring gratification, or provide nurture." Helplessness is an issue at

the core of depression because the person is living within a negative cognitive set which causes him to doubt his plans and goals. In short, he feels trapped.

Summary of Treatment

Treatment, like depression itself, is multifaceted, and according to Lerman and Baron (1981) should include a wide variety of cognitive, affective, behavioral, and interpersonal learning components. They (1981, pp. 86) state, "Managing depression is a journey, not a destination ... with the goal of reduction rather than elimination of depression in the individual's life situation." They encourage a proactive or "active mastery" philosophy in dealing with depression. Lerman and Baron advocate a structured group approach, referred to as Depression Management Training (DMT), which teaches individuals to identify their depression, understand the relationship between coping and depression, and learn coping strategies through practice of behaviors. They (1981, pp. 87) state, "The intent is increased awareness and knowledge of the nature of depression as well as the acquisition of skills in more effective coping with or, preferably, prevention of dysfunctional depressive experiences." DMT is a broad-based approach which has been evaluated by participants as being valuable because common experiences are shared and a mutual exploration of helping coping strategies is facilitated (Lerman & Baron, 1981).

Depression may also be managed on an individual level with the counselor serving as facilitator. McBrien (1981, pp. 429-430) states, "Depressed persons interact with their environment in such a way that they do not experience a sufficient number of pleasant events. The behavioral treatment of depression is designed to help the client experience increasing numbers of pleasant events. The key component in this system is positive reinforcement of the specific behaviors known to be incompatible with depression." Through a self-management approach the client is taught coping skills, including self-

monitoring, self-measurement, self-mediation, and self-maintenance. Probably the greatest factor in this individual approach is assessing the client's motivation to change. "The counselor's goal is to coach the client to plan and experience as many pleasant events as possible," McBrien (1981, pp. 431). By focusing on pleasant events, the counselor can discover if other dynamics, such as negative automatic thinking, unresolved grief, guilt, or mismanaged anger are involved. These problems may require counseling shift in focus to a deeper level.

Individual cognitive therapy was developed by Beck. Cognitive therapy views depression as dysfunctional cognitive patterns which are activated either by specific stresses or by overwhelming, nonspecific stresses. Beck (1967, pp. 318) states, "When the cognitive patterns are activated, they tend to dominate the individual's thinking and to produce the affective and motivational phenomena associated with depression. Cognitive psychotherapy may be used symptomatically during depressions to help the patient gain objectivity toward his automatic reactions and counteract them." It begins with a developmental reconstruction of depression in the client. This enables him to see what specific problems rather than symptoms led to his depression. Beck (1967, pp. 319) states, "The increased objectivity and understanding removes the mystery and may then provide a measure of mastery of the problems." The second step is to neutralize automatic thoughts. Often the client is unaware of his specific depression-generating cognitions and needs to focus in on them more clearly. Beck (1967, pp. 321) goes on to state, "These self-statements or cognitions reflect the distortions that occur in the depressed state. But when he can identify the distorted cognitions, and can acquire objectivity towards them and correct them, he can neutralize some of their pathogenic quality." Once the client is aware of his automatic, dysfunctional thoughts, he can learn to respond to those thoughts. "By stating

precisely why it is inaccurate, inappropriate, or invalid ... the patient is able to reduce the intensity and frequency of the idea as well as of the accompanying effect," Beck (1967, pp. 325). By telling himself specifically how he is thinking dysfunctionally (ex: "I'm thinking negatively."), the client can reduce the depressive cognition's power.

Drug therapy is another facet of treatment. According to Ubell (1988), three groups of medicines exist: tricyclic antidepressants, monoamine oxidase inhibitors, and lithium. All three alter the brain's chemicals and are used to restore to normal the client's mood, appetite, energy level, outlook, sleep patterns, and concentration. Side effects are usually mild. Weinrach (1988) states, "As yet we do not know exactly which patient is going to respond best to cognitive therapy and which will respond best to pharmacological therapy ... the combination of cognitive therapy and drug therapy is better than drug therapy alone--a very important distinction. So if patients have to be on drugs, they should get cognitive therapy with it." Davis and Maas (1983, pp. 419) write, "Studies have found that the combination of psychotherapy and a tricyclic is better than either treatment alone or than no regular treatment. The combination provides a broader spectrum of action as each treatment may affect different domains." They go on to say that psychotherapy focuses on social and interpersonal areas while drugs work on the physiological symptoms of depression.

Exercise is also to be considered in the treatment of depression. According to Monahan (1986, pp. 192), "Individuals who engage in regular exercise of varying intensity report significant reductions in anxiety and depression, improved sleep and appetite, better concentration, even better academic performance." One theory is that exercise gives the client a sense of mastery, achievement, and control. Whether exercise must be aerobic is still being studied; however, Monahan (1986, pp. 196) goes on to state, "We rarely get

someone to start feeling better without substantial changes in the physical measures of cardiac efficiency. The bottom line is that exercise must be aerobic. The key is to get depressed persons to sweat." The counselor's responsibility is to monitor the client's exercise goals to ensure they are realistic, since depressed people tend to be critical of themselves and set impossibly high standards.

Treatment Methodology

Lerman and Baron's article on a group approach in depression management training gives guidelines for facilitating the group and selecting group members as well as an outline for each session. Their group approach begins with identification of individual depressive symptoms within a small group atmosphere, then moves on to the identification of negative self-talk. Next the group works on reinforcement principles, awareness exercises, interpersonal consequences of depression, and finally a review of sources of depression and coping strategies. Using these guidelines, the counselor can plan an effective, comprehensive group experience.

On an individual basis, management plans geared toward the client help him to gain coping skills which result in greater self-control. By learning to monitor his own behavior, objectively record events, reinforce positive behavior, and keep this process going over time, the client becomes much more aware of his cognitions and behavior. Consequently, he is better able to dispute his negative thoughts and effectively manage his depression. This approach causes the client to take an in-depth look at himself and his situation, and he begins to know himself and why he thinks as he does. The key to depression management is self-awareness. The planning and experiencing of pleasant events instills hope because the client recognizes that positive things do occur; he is the one who chooses to permit more of these events in his life. Through cognitive therapy a truly motivated client can

learn to manage his depression on a daily basis by learning to understand his thinking and neutralize distorted automatic thoughts. When the client can recognize a dysfunctional thought and state why it is invalid, attitudinal structures begin to change. Often the client doesn't realize how many negative thoughts he is telling himself daily.

Awareness of the benefits of drug therapy and exercise are important because a counselor needs to know of all the options open to his client in order to serve him best. Since much depression stems from chemical imbalances in the brain, it is important that the counselor consider drug therapy when planning a management program. Often times physiological symptoms must be treated as well as the cognitive issues. Through a limited knowledge of antidepressant medication and its effects on depression, the counselor can make appropriate medical referrals to help the client gain additional assistance if needed. Exercise is beneficial because of the sense of achievement it instills in the client. Physiological results are reduced blood pressure, heart rate, and body weight. Exercise also helps the client to focus on something outside himself while at the same time reaping internal benefits.

Summary

Depression is an often misunderstood disease which has no cure. Rather, the goal of therapy is to reduce its effect on the individual client through self-awareness, acquisition of coping skills, and reinforcement of behavior incompatible with depression. Depression is characterized by withdrawal, hopelessness, insomnia, and physical pains, to name a few. The depressed client is struggling to cope with his environment using his own personal skills. The counselor's role is to teach the client to effectively manage his depression on a daily basis. More people than we realize suffer from this disease; however, society views depression as unacceptable, so the depressed person often hides behind a facade to escape

the social stigma. Repression is the price we pay for denying our depression rather than facing it head-on. The depressed person sees even small tasks as monumental and is convinced he can never be successful. In short, he feels powerless and a lack of control.

Depression is treatable through group therapy, individual management plans, and cognitive therapy. Often therapy is combined with medication in order to treat physiological symptoms as well as the cognitive domain. Exercise is being recognized as an integral part of a depression management plan; its physical and mental benefits continue to be affirmed as research progresses.

In summary, clients need to know that many others are struggling with the same depression-related issues day by day. We are to see our depression as a journey rather than a destination, with the goal being reduction rather than elimination of the disease in our lives. When the world insists on only feeling good, we are to deal with our feeling bad through increased self-awareness, acquisition of effective coping skills, and prevention of depressive experiences (Hazleton, 1984; Lerman & Baron, 1981). The counselor seeks to help his client to own his depression and manage it daily. McBrien (1981, pp. 432) summarizes it well, "Clients completing the program successfully have information that they have accepted responsibility for self-change and have learned coping skills that can be used throughout their lives. That, in my view, is the goal for each client we encounter."

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